INDIANA COMMISSION ON MENTAL HEALTH

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MEETING MINUTES[1]

Meeting Date:	**October 30, 2000**
Meeting Time:	**10:00 A.M.**
Meeting Place:	**State House, 200 W. Washington St., the House Chamber**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**6**

Members Present: **Rep. Susan Crosby, Chairperson; Rep. Gloria Goeglein; Sen. Steven Johnson; Robert Bonner; Galen Goode; John Huber; Gloria Kardee; Jerri Lerch; Amelia Cook Lurvey.**

Members Absent: **David Giles; Sen. Cleo Washington; Stephen Spindler; Judith Tilton; Janet Marich.**

Representative Susan Crosby (Chairperson) called the Indiana Commission on Mental Health (Commission) to order at 10:15 a.m.

[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.ai.org/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

Janet Corson, Director, Division of Mental Health

Ms. Corson distributed a handout entitled "Recommendations for Comment" (Exhibit #1). Ms. Corson stated that in January a group was assembled to review the recommendations contained in the National Association of State Mental Health Program Directors Office of Technical Assistance Consultation Report. The group endorsed the following recommendations:

- The Division of Mental Health (DMH) should not implement a Medicaid managed care system for mental health and addiction services, but rather improve the functioning of the current system.
- DMH should continue to develop community based services.
- DMH should support the identification and utilization of best practices to reduce the length of stay for state hospital patients and to promote integration and stabilization of patients in the community upon their discharge.
- DMH should continue to move non-forensic mentally ill adults, who have been in a state hospital for more than one year, into community settings.
- An advisory committee for the Office of Consumer Affairs should be created.
- DMH should actively seek the involvement of consumers and family members in planning and policy decisions.
- The next actuarial study should include a focus on co-occurring disorders.
- Treatment options for individuals with co-occurring disorders should be expanded.

Responding to questions by members of the Commission, Ms. Corson stated the following:

- DMH's next actuarial study will include data on co-occurring disorders.
- DMD and the Division of Disability, Aging and Rehabilitative Services are working together to determine how to serve individuals who are dually diagnosed.
- If DMH receives additional funds the money will be used on the goals outlined in her comments.

Diane W. Arneson, President, National Alliance for the Mentally Ill - Indiana

Ms. Arneson distributed her remarks to Commission members (Exhibit #2). Ms. Arneson made the following points in her testimony:

- The U.S. Supreme Court decision in Olmstead has brought about a more dramatic increase in funding of community mental health care than occurred when the State de-institutionalized patients.
- Funding for seriously mentally ill (SMI) adults and seriously emotionally disturbed (SED) children needs to be greatly increased.
- It must be made easier for a law enforcement officer to get a person into treatment so the person does not go to jail by default.
- Last fiscal year the Southwestern Indiana Mental Health Center had 2700 enrollees but were only paid for 953 of the enrollees, which means about 64% of the Center's care was charity work.

Jim Jones, Executive Director, Indiana Council of Community Mental Health Centers

Mr. Jones distributed a copy of a report entitled "The Hoosier Assurance Program, a Provider Critique" (Exhibit #3). Mr. Jones highlighted some of the areas discussed in the report, including the following:

- The Hoosier Assurance Program[2] has been drastically underfunded since its beginning. In fiscal year 2000, DMH only reimbursed mental health providers for 51% of their SMI and SED enrollments.
- DMH is supposed to fund the gaps in coverage for Medicaid eligible individuals and fund all the care for persons in need who are not Medicaid eligible.
- The enrollment rates for the Hoosier Assurance Program do not provide enough funds to assure that the person being treated receives the full continuum of care that is required.
- The Hoosier Assurance Program has helped state government to focus its limited resources in the most judicious way possible.
- The Hoosier Assurance Program appears to be a consumer entitlement program that is based on eligibility criteria. However, since it is limited by law to appropriated funds consumers may not be aware when the perceived benefit is no longer available to them.
- The State provides more money to a mentally ill person in a state operated facility to get them into the community than to keep the same type of mentally ill person who is in the community from going into a state operated facility.
- The State needs to spend about $6 million more per year to care for the people on the Hoosier Assurance Program waiting list. The need is actually higher because many people do not bother being placed on the waiting list because of the long wait to receive assistance.
- The 38.26% state match for Medicaid Rehabilitation Option services for all three of the Hoosier Assurance Program populations is subtracted from the state funds allocated for seriously mentally ill adults and transferred to the Office of Medicaid Policy and Planning. The impact of this transfer is that when the funds are used to match Medicaid services for children and substance abuse adults, the available funds for seriously mentally ill adult enrollments into the Hoosier Assurance Program are substantially reduced.

Mr. Jones made the following recommendations:

- That the SMI budget be split into three parts.
- That DMH's appropriation for the next fiscal year be increased as follows:
    - $15 million for community treatment enrollment funds.
    - $6 million for residential/transition service funds.
    - 3.5% for other service contracts.
- That DMH not add new providers to the mental health system until DMH has made a determination that existing providers cannot provide the services.

[2] The Hoosier Assurance Program was established from legislation contained in HEA 1376-1994.

Dr. Suzanne Greshem, Director, Comprehensive Mental Health Services

Dr. Greshem stated that she has worked in the mental health area for about 22 years and has observed many changes concerning mental health over the years. The Hoosier Assurance Program has caused many positive changes. Indiana's current mental health system is comprised of three components: state operated facilities; managed care providers; and community mental health centers (CMHCs). The state's mental health system does not include incentives to encourage the three components to work together. The CMHCs have been in existence for about 24 years and are an integral part of providing mental health services. All CMHCs are available 24 hours a day to provide help and many local governmental entities turn toward CMHCs for help (e.g. law enforcement, schools). The current mental health system encourages competition between CMHCs but since the entire system is grossly underfunded this competition ends up hurting CMHCs. The Division of Mental Health has taken money targeted for SMI adults and used the money to discharge into the community adults who have been in state operated facilities for more than three years. Though Dr. Greshem agrees with DMH's goal to remove people from state operated facilities, 25 mentally ill individuals in the community could be served from the same amount of money needed to move the one person out of the state operated facility. In closing Dr. Greshem stated that the economy and stagnant funding levels have made it impossible for CMHCs to compete for quality workers.

Dr. Robert Williams, Quinco Mental Health Center

Dr. Williams explained to the Commission how penetration rates are calculated for a CMHC service area and how the rates that CMHCs receive are determined. Indiana has a higher percentage of rural areas when compared to surrounding Midwest states. The costs of providing mental health services in rural areas are higher than in urban areas because of higher costs for services like transportation. Quinco has higher yearly costs than many other CMHCs for each residential bed that they operate. Dr. Williams would like to see the bias in funding against rural CMHCs come to an end.

Carla Gaff Clark, Ed. D. Mental Health Counselor, Indiana Addictions Issues Coalition

Ms. Clark explained that most of the clients that she sees are individuals who are homeless and dealing with a dual diagnosis (e.g. mental illness and addictions). Most of these individuals are struggling with problems that they experienced in their childhoods (e.g. molestation, addicted family member, etc.). Children who are exposed to an addiction are at high risk of developing the same addiction later in life. An addiction that is not treated costs the community about $32,000 per year through other costs.

Stephen McCaffrey, President, Mental Health Association of Indiana

Mr. McCaffrey stated that the Hoosier Assurance Plan is a good plan if it is adequately funded. The director of DMH has done a good job with the funds that have been appropriated. The first goal of DMH should be to secure increased funding to meet the need of the mentally ill as opposed to reducing the continuum of care that is offered or increasing eligibility standards. Based on data from the actuarial study there are not any areas of mental health that are adequately funded.

Mr. McCaffrey made the following recommendations:

- That funding for CMHCs to treat SMI adults be increased by $21 million, and addictions funding be increased by $10 million.
- That health insurance statutes that provide for mental health parity be amended to include parity for substance abuse.
- That Dawn Projects be replicated throughout the state.

Lisa Gibson, Indiana Depressive and Manic Depressive Association

Ms. Gibson stated that the Indiana Depressive and Manic Depressive Association is a consumer based organization that educates the public and works to reduce the stigma of mental illness. Ms. Gibson shared her own story of dealing with mental illness. She graduated from college with honors but her mental illness caused her to lose nearly everything she had (e.g. job, car, home, etc.). She stated that with appropriate community services she could have recovered much faster and at less cost. The Indiana Depressive and Manic Depressive Association supports providing the full continuum of care to the mentally ill through the expansion of funds and programs under the Hoosier Assurance Plan, providing adequate resources to move people out of state operated facilities, and providing the SMI adults in the community with opportunities for education, employment, and a home.

Commission Recommendations

The Commission then began discussing and adopting recommendations and a final report.

The Commission adopted the following proposed legislation:

- PD 3584 (as amended) - the expansion of Dawn Projects throughout the state - by a vote of 9-0.

- PD 3500 - substance abuse parity - by a vote of 9-0.

- PD 3605 - prohibition on custody relinquishment - by a vote of 9-0.

- PD 3606 - mental health provider determination - by a vote of 9-0.

- PD 3619 - Children's mental health task force - by a vote of 9-0.

- Increase DMH appropriation per recommendation in the final report - by a vote of 9-0.

The Commission reviewed and amended its final report. Additional final report recommendations included:

- That the Commission examine issues related to the utilization of state operated facilities, especially as it relates to the costs to counties that have to wait to place individuals in state operated facilities.

- That DMH's appropriation for the next fiscal year be increased as follows:

- $15 million for community treatment enrollment funds.
- $6 million for residential/transition service funds.
- 3.5% for other service contracts.

- That an additional $10 million be spent on addictions and substance abuse.

The Commission voted to adopt the final report, with amendments, by a vote of 9-0.

The Chairperson adjourned the meeting at 12:30 p.m.